TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: referral@12stonehealth.com

IMMUNE GLOBULIN ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

Provider Information

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER

Immune Globulin
Brand
(if specified):

_____

(TwelveStone will assist with payer formulary restrtictions, ect.)
Excludes: Flebogamma Gammaked

☐ Intravenous:
Administer _____ gm/kg per day for _____ days.

☐ Intravenous:
Administer _____ gm/kg over _____ days every _____ weeks.

☐ Subcutaneous: Administer _____gm/kg per day for _____ days every _____ weeks.

✓ Please select weight to be used for dosing purposes:
If no selection chosen, Actual Body Weight will be used.

☐ Actual Body Weight
☐ Ideal Body Weight
☐ Adjusted Body Weight

Refills for one year from date of signature unless indicated below.

_____ Refills

Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:

✓ BUN and Creatinine

PRE-MEDICATIONS

Oral

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg
☐ Loratadine: 10mg
☐ Cetirizine: 10mg
☐ Diphenhydramine: ☐ 25mg ☐ 50mg
☐ Famotidine: ☐ 20mg ☐ 40mg
☐ Ibuprofen: ☐ 200mg ☐ 400mg ☐ 600mg
☐ Ondansetron: ☐ 4mg ☐ 8mg
☐ Other: _____

IV

☐ Dexamethasone: ☐ 4mg ☐ 8mg
☐ Diphenhydramine: ☐ 25mg ☐ 50mg
☐ Famotidine: ☐ 20mg ☐ 40mg
☐ Methylprednisolone: 125mg
☐ Hydrocortisone: 100mg
☐ Ondansetron: ☐ 4mg ☐ 8mg
☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature *(SIGN BELOW)*

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written:

_____ _____
Prescriber Signature Date

Substitution Allowed:

_____ _____
Prescriber Signature Date